roxbury
SURGERY CENTER

Submit Form

| Patient's Name: Last, First, Middle Initial | | S.S. # | Marital Status<br>M I S I D I W I Sep<br>❑ ❑ ❑ ❑ ❑ | Birth Date |
|---|---|---|---|---|
| Street Address | | City, State. Zip | Preferred Phone | |
| Patient's Employer | | Occupation | Alternate Phone | |
| Employer's Address | | City, State. Zip | OK Leave Message<br>❑ YES ❑ NO | |
| Drug Allergies, If Any | Are you Diabetic? | Driver's License# | Email Address | |

| Spouse/Partner's Name: Last, First, Middle Initial | S.S. # | Birth Date |
|---|---|---|
| Address if Different from Patient | City, State. Zip | Preferred Phone |
| Spouse/Partner's Employer | Occupation | Alternate Phone |
| Employer's Address | City, State. Zip | OK Leave Message<br>❑ YES ❑ NO |

| In Case of Emergency, Notify | Relationship | Home Phone |
|---|---|---|
| Referred By | Relationship | Home Phone |
| Insured Name | Effective Date | Certificate/ Policy# Group# |
| Name of Insurance Company | HMO<br>❑ YES ❑ NO | Subscriber # |
| Insurance Address | | City, State, Zip |
| Referring Physician | | Business Phone |

AUTHORIZATION OF TREATMENT ASSIGNMENT OF BENEFITS RELEASE OF MEDICAL INFORMATION FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for charges incurred at the time of service or for any charges not covered by an approved contractual-provider insurance or insurance benefits. I am also responsible for any collection fees or legal costs incurred should costs be necessary because of non-payment. I hereby authorize the release of any medical records or other information necessary for the processing of insurance benefits of medical and/or surgical services rendered. I hereby authorize payment of benefits directly to Roxbury Surgery Center for the procedural, surgical and/or medical benefits if any, otherwise payable to me for their service.

HMO patients please be aware you are financially responsible for all unauthorized services.

Roxbury Surgery Center is a physician owned facility. I understand that my physician may have financial interest or ownership in Roxbury Surgery Center. A full list of physician owners will be provided at my request in writing.

I hereby authorize treatment by Roxbury Surgery Center.

| Signature of Patient, Guarantor or Guardian | Date |
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